Local Access to Universal Health Care in Lewis & Clark County

A Report from the Lewis & Clark City-County Board of Health
October 2010

"It doesn't seem fair that I have access and other people don't."
(Focus Group Participant)

Executive Summary

In December 2008, the Lewis & Clark City-County Board of Health (BOH) adopted a resolution recognizing the human right to health and health care, along with the corresponding government obligation to guarantee universal access to care, and set up a Task Force comprised of residents and health providers to assess local health needs and prepare an action plan for securing universal access to health care in the county.

This report summarizes the Task Force's community health needs assessment, which includes an overview of the community's health status, the availability and use of health services, and an in-depth exploration of barriers to accessing health care. The Task Force also collected views and suggestions from community members on the human right to health care and the role of the local government in protecting this right, along with specific suggestions for local reform. Phase II, to be completed by the end of 2010, will outline the components of an action plan for making universal health care plausible in Lewis & Clark County.

The findings below represent key issues identified by participants in nine community focus groups, provider surveys and a community survey, supplemented by a review of secondary data.

Summary of Findings

- Lewis & Clark County is designated as a health professional shortage area, with 21% of its population considered medically disenfranchised. The shortage of primary care doctors, dentists and mental health professionals was confirmed by community members and providers. This shortage deprives county residents of needed care, contributes to stress among existing providers and puts the health of the community at risk.

- Existing providers – both primary and specialists – are not readily accessible to poor, low-income and rural residents, resulting in unequal access to care across the county.

- A majority of respondents felt that the loss of primary care providers has adversely impacted access to health care in Helena.

- The cost of health services is a key barrier to health care access, both for insured and uninsured residents. Many residents with insurance have difficulty using their coverage, due to deductibles and co-pays, or to providers not accepting Medicaid. Providers are concerned about low Medicaid reimbursement rates;

however, many who participated in the Task Force's survey reported that they continue to accept Medicaid patients. Few access problems were reported by residents enrolled in Medicare or the Veteran's Administration.

- Lack of transportation is a barrier to accessing needed health care services, both in the rural parts of the county where residents are dependent on cars and in Helena, where public transit is limited and street design does not encourage walking and biking.

- Around 28% of people in Lewis & Clark County lived below 200% of the Federal Poverty Level (less than $20,000 for one person in 2009; $40,000 for a family of four) between 2006 and 2008. A majority of participants in the Task Force's focus groups fell into this bracket, and many reported foregoing health care due to cost concerns.

- Dentists in Lewis & Clark County estimate that 85% of the disease they see is preventable and, when asked to name the greatest oral health need in the Helena area, 40% said access to affordable dental care.

- Estimates of the proportion of county residents without insurance range from 14% (2005 census data) to 21% (2007 Health Indicators Report for Lewis &Clark County). Many more are underinsured. The number of visits by uninsured patients at the Cooperative Health Center increased from 24% in 2001 to 60% in 2007.

- An estimated $385 million was spent on health care in Lewis & Clark County in 2008; if health care financing and administration in the county reflects national trends, it can be assumed that roughly 31% - 34% of that $385 million was consumed by administrative costs.

- Both residents and providers have concerns about the county's only hospital, St. Peter's Hospital in Helena. Residents perceive that the hospital is not providing quality services for community members. Providers attribute, in part, the high turnover of primary care providers to dissatisfaction with hospital administration.

- The majority of participants in the focus groups and the community survey considered health care to be a human right (60% and 72%, respectively). Many expressed this in terms of an equal right of access to care for all. Many participants stressed that to have a healthy community, the government or the local community should help everybody to be as healthy as possible.

- Residents and health professionals offered specific suggestions for local reform, including expanding primary, mental and dental care services, supporting existing primary care providers and the Cooperative Health Center, increasing transportation options, and reducing cost barriers to access. The Task Force will consider these and other suggestions in Phase II of its work.

Introduction and Background

In December 2008, the Lewis & Clark City-County Board of Health (BOH) adopted a resolution recognizing the human right to health and health care, along with the corresponding government obligation to guarantee universal access to care, and created the Task Force on Local Access to Universal Health Care. It was the board's stated concern that county residents who lack access to health care, in particular those who are uninsured or underinsured, suffer from poorer health outcomes, including greater risk of chronic disease and premature death, than those with a regular source of care. Because the BOH is charged with improving and protecting the health of county residents, its members view access to health care as a significant public health issue and accept responsibility to ensure access for all at the local level.

The Task Force appointed by the BOH was charged with the dual mission of assessing the community's health needs, and identifying and prioritizing actions to meet those needs and ensure universal access. The Task Force, comprised of county residents, health care providers and other health sector representatives, was given two years to complete this multi-phase project. The group organized itself into four working groups that evaluated different aspects of this complex issue. The working group on health status and health services carried out secondary research to supplement the county's biannual review of community health outcomes and health services. A second working group was tasked with reaching out to the community to hear about unmet health needs, and to give community members a voice in how their needs could be met and access be improved. Similarly, the third working group obtained health care provider views on patient health, access to care, availability and quality of services, and suggestions for local reforms. The final working group reviewed the financial and legal context of health care delivery in the county, including current spending on health care and coverage.

It should be noted that the members of the Task Force volunteered their time for two years to fulfill their mission and worked without a designated budget.

This report summarizes the work of the Task Force in Phase I, which encompassed a year-long assessment of where we are as a community in terms of our health status, our health needs, our understanding of access barriers and our overall views of the health care system in Lewis & Clark County. As tasked by the BOH, this assessment:

- Defines the scope of the lack of access to quality health care in Lewis & Clark County;
- Identifies the impacts this lack of access has upon health status and life expectancy of county residents, paying special attention to those who are uninsured or underinsured;
- Identifies the leading causes of or contributing factors to lack of access to health care;
- Correlates this local information to state and national data and trends;
- Collects and reports on the experiences and views of community members;
- Engages community members in an assessment of their needs;
- Consults with community members about how their health care needs can best be met and seeks their views on action options for universal access, and
- Identifies options to address the health problems and needs in our county.

Phase II of the Task Force's work, to be completed by the end of 2010, will outline an action plan that:

- Identifies and prioritizes specific actions the BOH and Lewis & Clark County City-County Health Department (the Department) should consider to address the lack of access to health care, with particular emphasis on local options for universal health care;
- Sets principles, objectives and benchmarks for preferred options, and
- Identifies specific strategies, actions and recommendations that local government officials should make to state and federal leaders regarding the best options for addressing the lack of access to health care and achieving universal health care in Lewis & Clark County.

See Appendix 1 for the complete language of the resolution, the members of the Board of Health and the community members appointed to the Task Force.

Methodology

The Board of Health Task Force on Local Access to Universal Health Care (Task Force) used both primary and secondary data to complete Phase I of its work. The Task Force relied on a substantial amount of current local, state and national data, and reached out to community members, community organizations, health professionals, academic experts, and other stakeholders to compile a detailed picture of health care needs and access in Lewis & Clark County.

For its initial review, the **Working Group on Health Status and Service** reviewed secondary sources to summarize the health of county residents and issues affecting access to care. Sources ranging from the U.S. Census Bureau, the Centers for Disease Control and the U.S. Department of Health and Human Services to our state and county health departments provided the most current information for the group's document, *Status of Health and Health Services in Lewis & Clark County*, which appears in Appendix 2 of this report.

The **Finance Working Group** also relied on secondary sources for identifying how local health care access is financed. Due to a lack of data at the local level, many of the group's conclusions were extrapolated from state and national data. Sources included Dr. Steve Seninger, senior research professor at UM's Bureau of Business and Economic Research and former director of the Bureau's Health Care Policy Research Program; the Kaiser Family Foundation and its state-by-state analyses of health spending and coverage for health care services; and tailor-made reviews by a human rights law clinic at American University, including an analysis of successful universal health care models in other U.S. counties. The Finance Group also considered a cost-benefit analysis of a hypothetical universal health care model in Montana by Anne Alexander, an economist and department chair at the University of Wyoming. These documents appear in Appendix 5 of this report. The issues raised in these documents will be considered in greater depth in the Phase II report addressing action recommendations to expand local access to health care.

The Community and Provider groups sought the views of local residents and health care providers, respectively.

The **Community Working Group** reached out to many community-based and non-profit organizations in the county, with the support of the Montana Human Rights Network, and conducted nine focus groups comprised of 56 individuals in Helena, Canyon Creek, Lincoln and Augusta between August and November 2009. These community groups talked about people's health needs, access barriers to care, availability of services, quality and acceptability of services, and accountability of the health system. Participants debated the role of government in protecting this right, and made specific recommendations for reforms at the local level. Details of their methodology are included in the full focus group report which appears in Appendix 3 of this report.

In an effort to spread a wider net and gain additional public opinion on health care and access issues in Lewis & Clark County, the Task Force distributed a community survey in April 2010 that could be accessed online and in print. Printed copies of the 23-question survey were distributed in Helena, Canyon Creek, Lincoln and Augusta. The opportunity to participate in the survey was broadly advertised throughout the county. The informal survey yielded 305 responses, and also appears in Appendix 3.

The **Provider Working Group** focused primarily on primary care with additional information about access to dental services in Lewis & Clark County. The group inventoried primary care physicians and internists in the county, and sent written surveys to primary care doctors to assess the impact of recent physician departures and to understand factors affecting physician retention. The group received 17 responses out of 27 questionnaires mailed. Fifty-eight questionnaires were also sent to nurse practitioners and physician assistants; the group received 27 responses. A summary of responses to these questionnaires appears in Appendix 4A.

The group also surveyed dental professionals, using written questionnaires and personal interviews. A survey of 33 dentists and two oral surgeons in Lewis & Clark County yielded 10 responses. The questionnaire and survey summary also appear in Appendix 4.

Findings of the Four Working Groups

Health and Health Services in Lewis & Clark County

Reviewing available data from the county's biannual health profiles, the Montana Department of Health and the U.S. Census Bureau, the Working Group on Health Status and Services set out to compile a picture of health and health care services in Lewis & Clark County. Given the Task Force's mandate, the review sought to understand the community's health needs within their socio-economic context, highlight health problems related to health care access, and identify gaps in services and barriers to health care access. The group's detailed report appears in Appendix 2, with highlights of the data summarized below.

Health Status and Needs

- The poverty rate in Lewis & Clark County was close to 11% in 2008, below national and state levels. Poverty is linked to greater health needs and poorer health outcomes. Around 28% of the county's population lived below 200% of the federal poverty level between 2006 and 2008, compared with 33% of Montana's population as a whole. This means that almost a third of the county's population lives on very low incomes or no incomes at all and likely have difficulties obtaining healthy food, quality housing, reliable transportation and comprehensive health care.

- Around 9% of Lewis & Clark County residents relied on the Supplemental Nutrition Assistance Program (food stamps) to buy groceries in early 2010. Nutritious food is often beyond the reach of many living in poverty or on very low incomes. It is more expensive than processed foods and not as easily obtainable, especially outside Helena.

- The health of the population in Lewis & Clark County is in line with state and national averages. Around 12% of adults reported fair or poor health between 2000 and 2006, which is better than average compared with peer counties. However, the following health issues may require attention:
  - The breast cancer death rate (32.3 women per 100,000) is higher in Lewis & Clark County than nationally (25.3) and in peer counties (20.3 – 32.1).
  - Mental health issues appear to be particularly prevalent in the county, reflecting a statewide problem. Lewis & Clark County averaged 18.2 suicides per 100,000 people between 2000 and 2006. By comparison, the national rate is around 11 suicides per 100,000, with Montana ranking highest in the country at 19 suicides. An indication of the underlying prevalence of mental health issues may be that in the first half of 2008 around 70% of all patients at the Cooperative Health Center were diagnosed with mental health disorders.

- Lewis and Clark County is designated as a rural county, yet with 18 persons per square mile is very close to frontier status. Most services are concentrated in the city of Helena (28,726 pop.), which is home to the county's largest employer, local and state government. Outside of Helena, distances are far and communities are relatively isolated. People are reliant on cars for transportation, with very limited access to public transportation, even in Helena. Transportation barriers likely prevent many people from seeking needed health care.

Health Services and Insurance

- Lewis & Clark County is designated as a health professional shortage area, with 21% of its population considered medically disenfranchised. Health services are concentrated in Helena, with very few services located in more rural areas of the county.

- The county has a federally qualified health center, the Cooperative Health Center in Helena, which also operates a satellite clinic in Lincoln, the Parker Medical Center. Since opening in September 2007, the Parker Medical Center has had 700 patients. In 2007, the Cooperative Health Center had 5,590 patients who made over 21,000 visits. The number of visits by uninsured patients increased from 24% in 2001 to 60% in 2007.

- The county's general hospital, St. Peter's, is a private, non-profit facility based in Helena. In 2006 St Peter's spent 1.57% of its revenue on charity care, as part of an overall 4.49% spending on uncompensated care, which includes charity, bad debts, and Medicaid costs that exceed reimbursement. This compares to a national average of 5.7% spending on uncompensated care by non-profit, tax exempt hospitals.

- Estimates of the number of uninsured people in Lewis & Clark County range from 14% to 21%. By extrapolating state data to the county population, the Working Group on Health Status and Service estimated the following:
  - 16% uninsured
  - 50% with employer-sponsored insurance
  - 14% Medicare
  - 12% Medicaid and CHIP
  - 8% with individual-market insurance

  This estimate largely correlates with available county-level data for public insurance programs: in 2008, 11% of county residents were enrolled in Medicare and CHIP, and 16% in Medicare.

- According to a 2000 white paper published by the Montana Dept. of Public Health & Human Services, 'Studies of states with sliding scale premiums show that low income individuals are more likely to sign up for coverage if premiums are no more than one to three percent of their income. At five percent of income, participation drops significantly."

  In 2010, Kaiser Family Foundation found the average annual premiums are $5,049 for single coverage, well over 5% of the average income in Lewis & Clark County.

Community experiences and views on health needs and rights

Task Force members conducted nine focused discussion groups with a total of 56 community members in Helena, Augusta, Lincoln and Canyon Creek to assess people's health needs and collect their suggestions for improving access to care. Participants were recruited with the help of

local community organizations, with a view to prioritizing the participation of uninsured, lower-income and rural residents who are likely to be most affected by poor access to care. The profile of participants shows that a diverse cross-section of community members took part, and while poor people were relatively under-represented in rural locations, overall there was good representation from lower-income and uninsured people.

The focus groups discussed the current state of the health care system in Lewis & Clark County, including people's health needs, availability of needed services, experiences with accessing health care, quality and accountability of health services and issues of dignity. Additionally, participants offered suggestions for local health reform, and voiced their views on the human right to health care and the county's role in protecting this right.

Key Findings from the Community Focus Groups

- **Access (cost):** Cost barriers impede full access to health care, particularly for lower income people and the uninsured. Most participants have experienced difficulty finding health insurance, using the insurance they have, or paying out-of-pocket. Overall, participants noted that access to health care is dependent on a person's ability to pay for it, and recounted experiences illustrating that this has led to inadequate and unequal access to health care. Although the majority of respondents had insurance, many had sparse plans with high deductibles that often precluded them from using their insurance to pay for needed care. Because of the expense, participants reported forgoing care or waiting to get care until their condition had worsened and they could no longer avoid it. Most participants thought that access to care in the county was not equal, and many felt that access barriers, especially those due to cost, were unfair.

- **Availability of health care:** Residents generally noted a shortage of service providers in the county. Rural residents felt this particularly acutely, as did poor and low income residents. Reported problems ranged from a lack of services in isolated rural communities and a need to travel out-of-county to see specialists, to a shortage of providers accepting Medicaid patients. In particular, primary care doctors, dentists and mental health providers were reported to be in short supply and not readily accessible. Many participants reported that the health care system was not easily navigable, with barriers created both by insurers and providers. Moreover, awareness of available free or low-cost services (such as the Cooperative Health Center) was low. Dependence on personal transportation to get medical attention was noted as an issue for everybody, and of particular concern to rural communities.

- **Quality:** While there were many positive statements about the quality of care, particularly regarding the Lincoln Clinic, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Cooperative Health Center and volunteer ambulances, participants expressed serious quality concerns about some aspects of care, particularly related to St Peter's Hospital. Participants thought that the hospital was not providing an adequate service to community members, with examples ranging from poor quality care and long wait times to high costs and wasteful spending. Overall, many participants thought that providers were sometimes making business decisions that did not align with patients' needs.

- **Acceptability/dignity:** Concerns about dignity in accessing and receiving health services were raised by low-income residents – particularly the uninsured, Medicaid enrollees and residents seeking long-term mental health care. Poor people had experienced that providers treated them with little respect and made them feel like second-class citizens.

- **The human right to health care:** The majority of participants considered health care to be a human right. In particular, poor people, Medicare and Medicaid enrollees and students felt strongly supportive of the human right to health care, based on principles of equality and universality. Several others emphasized ethical obligations to meet health care needs, but did not feel comfortable expressing that in human rights terms. Overall, participants saw a collective responsibility for health and health care and stressed that to have a healthy community; the government or the local community should help everybody to be as healthy as possible.

- **Suggestions for reform:** Participants offered a range of suggestions for Lewis & Clark County, including expanding health care services, particularly primary care, improving care coordination, improving the navigability of the health system, improving transportation, and expanding financing options. A detailed list of suggestions is included in the Focus Group Report, Appendix 3A, and will be considered by the Task Force in Phase II.

The community focus groups enabled the active participation of a segment of the population that is particularly affected by poor access to health care. To give a larger segment of the population an opportunity to take part, and to gauge public opinion on health needs and access issues, the Task Force distributed a quantitative survey in April 2010 that could be accessed online and in print. It yielded 305 responses, mostly from women (68.4%), from people living in Helena (80.9%) and from those with middle to high incomes. Around 20% of survey respondents had incomes under $20,000, compared with 42% of participants in the focus groups.

While the survey offered primarily an impression of residents' views and experiences, rather than statistically valid results, the findings are nevertheless instructive, especially where they reinforce findings from the provider surveys and the community focus groups. Highlights of the survey appear below; complete results of the survey appear in Appendix 3B.

Key Findings from the Community Survey

- **Access (cost)**: Almost 16% of respondents had no insurance, mostly because they could not afford it. This rate correlates with estimates by the Working Group on Health Status and Services. Many respondents reported significant access barriers to care, regardless of their insurance status: 30% of respondents could not afford to get care, and 38% required health services that were not covered by their insurance company. 8% of respondents were unable to obtain medication due to cost. This reflects access barriers encountered by focus group participants.

- **Availability of health care**: Many respondents confirmed the shortage of health providers in the county: 18% could not get an appointment with a doctor, and 31% reported that their doctor left his or her practice. Respondents reported traveling outside the county to get health care: 65% saw a specialist outside the county, 27% traveled to other counties to see a dentist, and 18% left the county to see a primary care doctor. Others did not have the option to travel, within or outside the county: 7.5% reported that a problem with transportation prevented them from getting care.

- **The human right to health care**: The Task Force wanted to gauge whether respondents supported the Board of Health's recognition of the human right to health care. The majority did: 72% agreed that access to basic health care is a human right, regardless of income, age, or other factors. 16% disagreed, and 12% were not sure. Many who disagreed expressed their opinion that health care is a personal responsibility.

- **Suggestions for reform**: Respondents were asked about several options for improving health care access in Lewis & Clark County. Only 15% thought that health care in the county was adequate and required no improvement. The majority wanted to see improvements, especially expanded services at the Cooperative Health Center (58% of respondents suggested this) and more primary care doctors (53%). Many hoped to see more rural services (33%) and improved transportation (26%). Health care could also be improved through increasing the number of specialists (31%) and dentists (23%).

Health care provider experiences and views

A theme that appeared repeatedly during the information-gathering phase of the Task Force study is the shortage of primary care doctors in Lewis & Clark County, which has been designated by the federal Health Resources and Services Administration as a Health Professional Shortage Area. Statewide, the medically underserved population for primary care is estimated at 23% of the population. Residents expressed their perception of a shortage; many having watched their doctors leave their practices. Providers, too, acknowledge a doctor shortage.

The Health Care Provider Group surveyed primary care doctors and mid-level care providers (nurse practitioners and physician assistants) to get their views on the doctor shortage and access to health care services in the county. For the purpose of their study, they defined primary care providers (PCPs) as family practitioners and internists. They also surveyed dentists for their views on oral health services and needs.

Key Findings from the Provider Surveys

An inventory of PCPs in the county in May 2009 found 19 family practitioners in Helena and two in Lincoln, plus six internists in Helena, two of whom practiced internal medicine part time. At that time, 13 primary care physicians had left practice in the community within the previous 12 months. Since then, two internists and one family practitioner have left their practices, and one internist and one family practitioner have opened practices in Helena

Previous primary care losses occurred with the inauguration of a hospitalist program at St. Peters Hospital (SPH) in 2004. It was staffed with internists, most of whom had been primary care providers in Helena. The hospitalist jobs were attractive because they offered a salary and predictable work hours.

The Provider Group surveyed **primary care physicians** in Lewis & Clark County to assess the impact of recent physician departures on local health care and to understand factors affecting physician retention. A majority of respondents felt that the loss of PCPs has adversely impacted access to health care in Helena. However, the majority also reported that patients had to wait less than a month for a new patient appointment in their offices. Furthermore, a majority reported that they were accepting new Medicare, Medicaid and uninsured patients.

Other highlights of the PCP survey

- Top three sources of stress among providers: time constraints impacting family life, interactions with hospital/clinic administration and interactions with patients.

- Most pressing problems in their practice: uncompensated paperwork, reimbursement rates, office overhead cost and uninsured patients.

- Best options for improving physician retention: salaried jobs, assistance with student loan repayment and better reimbursement from Medicare and Medicaid. (Of note, the majority stated they had significant student debt when they started practice in Helena, with several respondents having debt exceeding $100,000.) Additionally, The MT board of medical examiners reported that over 39% of physicians in MT are over 50

- Local physicians cited the cost of their malpractice insurance premiums as a pressing problem. Those seeking to cut back to less than full time as they enter their 50's found that the cost of their malpractice insurance would not allow them to do so. Also, the option of Federal Tort Claims Act Coverage (FTCA) for malpractice insurance through the Cooperative Health Care Center or the VA was cited as a desirable option that might enable physicians who would otherwise retire completely as they near retirement continue to afford to work at least part time.

- The shortage of psychiatric care providers is an important concern among those providing mental health services. The Provider group was not able to study or address the provision of mental health services and recommend a thorough assessment by the Board of Health in the future.

The Task Force also surveyed **nurse practitioners** and **physician assistants** in the county. An overwhelming majority felt that access to medically necessary health care in Lewis & Clark County is a problem for their patients, and that lack of access caused harm.

- Top six barriers to care: the cost of specialty care, the cost of primary care, the cost of essential prescription drugs, lack of access to mental health services, lack of PCPs and cost of dental care.

The shortage of PCPs is not just a local issue. In a 2008 white paper by the American College of Physicians entitled "How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care," the authors state:

> While the demand for primary care is increasing, there has been a dramatic decline in the number of graduating medical students entering primary care. Factors affecting the supply of primary care physicians include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost of providing care. As a result, many primary care physicians are choosing to retire early. These factors, along with increased medical school tuition rates, high levels of indebtedness, and excessive workloads, have dissuaded many medical students from pursuing careers in general internal medicine and family practice.

A 2009 report ("Review of Physician and CRNA Recruiting Incentives") by Merritt, Hawkins & Associates, a national recruiting firm, notes a new trend toward hospital employment of physicians: "Many physicians, specialists in particular, are seeking hospital employment to relieve them of the stress of high malpractice rates, the struggle for reimbursement, administrative duties and the general risks and hassles of private practice."

From the Provider Group survey
"My staff spends about three-plus hours a day per person on paperwork…If Medicare and Medicaid paid better, the overhead would not be as critical."

"I strive for a salaried position!"

The Provider Group stated its concern that Helena is facing a worsening crisis of health care access, particularly to internal medicine services, due to national trends of fewer internists and

family practitioners, as well as from high local physician turnover due to dissatisfaction with current pay arrangements and with hospital/clinic management.

From the Provider Group survey
"With health care reform looming, the lack of primary care will be magnified as more patients try to access the system."

In its survey of chronic disease in Lewis & Clark County, the Working Group on Health Status and Service noted the correlation among health outcomes, cost of treatment and access to primary care: "Optimal access to preventive and primary care produces better health outcomes than treating advanced disease or acute episodes of illness." Similarly, they noted, suicide is best prevented through early recognition and treatment of depression and other psychiatric illnesses. Primary care providers' knowledge and recognition of suicidal behavior is essential to preventing suicide.

Dental Care

The Provider Group also surveyed dentists serving Lewis & Clark County to get a sense of oral health needs and barriers to access. About a third of Helena's 33 dentists responded to the group's survey. Respondents estimated that 85% of the dental disease they saw in their practice was preventable.

Asked to name the greatest oral health need in the Helena area:

- 40% said access to affordable dental care
- 20% said fluorinated city water
- 20% said access to regular preventive care, starting in early childhood

Dentists also ranked public education about dental care and expansion of subsidized dental services at the Cooperative Health Center as high priorities.

The CHC reports that according to federal Health Resources Services Administration standards, there are technically enough dentists to serve Lewis & Clark County. However, because 30% of the population live below 200% of the federal poverty level, there are 1.5 dentists for 18,277 low income people in the county (a ratio of 12,185 to 1), or three times the number of patients in need of the dentists available to care for them. All of the dentists responding to the Provider Group survey said they had a mix of Medicaid, insured and self-pay patients. Two who were not taking new patients said they continued to care for all of their existing patients, regardless of payment method.

Financing of Health Care in Lewis & Clark County

In order for Lewis & Clark County to consider options that would move the community toward universal access to health care, it is important to have an understanding of the dollars being spent on health care in our county. Potential reform options will require funding, so knowing how many dollars change hands and knowing the source of those dollars will help guide the options for reallocation of those dollars toward reform.

According to Dr. Steve Seninger, senior research professor at UM's Bureau of Business and Economic Research, total spending for health care in Montana was $5.4 billion in 2006, $5.8 billion in 2007 and $6.2 billion in 2008. Since no county-by-county spending estimates exist, the Finance Group extrapolated the following dollar amounts spent for health care in Lewis & Clark County, which comprises 6.2% of the Montana population:

- $334.8 million in 2006
- $359.6 million in 2007
- $384.4 million in 2008

According to the U.S. Census, the population of Lewis & Clark County was 60,925 in 2008. Therefore, about $6,300 was spent on health care for every man, woman and child in the county in 2008.

Based on a 2003 national survey, an average of 31% - 34% of our health care spending is actually spent on administrative costs (insurance overhead, practitioners' overhead, hospital and nursing home administration, employers' cost of administering health care benefits, etc.) rather than on direct patient care.

Phase II of the Task Force report will quantify the number of health care dollars spent locally that are controlled by the policy decisions of public/private employers and by individuals who purchase their own coverage. Any proposals to reform health care at the local level could conceivably redirect these dollars to create a more universally accessible local health care system.

Conclusion

All aspects of the community health needs assessment carried out by the Task Force between 2009 and 2010 confirmed that lack of access to appropriate health care in Lewis & Clark County is a serious problem demanding action at the local, county level. Community members and health providers alike highlighted the increasing shortage of primary care professionals, which deprives communities of essential care and puts significant stress on existing providers. This shortage extends to dentists and mental health professionals. The cost of services was identified as another key barrier to universal and equitable health care access. Both uninsured and insured community members expressed concerns not only about the cost of insurance, but also the financial burden of deductibles and co-pays, and many questioned the direct link between access to care and payment. Payment was seen as the main reason why some members of the community had better access to care than others, and many perceived this as an inequality that stood in the way of creating a healthy community. The majority of community participants in this project recognized this as a human rights problem.

Many residents suggested that an expansion of the services offered by the Cooperative Health Center could help alleviate problems of health care availability and access. This could include initiatives to address rural transportation barriers, for example through mobile clinics. Among providers, the administrative burden of running a private practice as a stand-alone enterprise was seen as a challenge, which corresponded to some patients' concerns about providers acting as businesses. Among both residents and providers this challenge prompted a reflection on options for enhanced provider collaboration and pooling of resources. In this regard, most respondents considered not only the role of the Cooperative Health Center, but also that of St. Peter's Hospital. Many respondents felt that the hospital had yet to step up and start considering how it could best contribute to meeting community health needs and supporting providers across the county.

Significant amounts of private and public dollars are currently spent on health care in Lewis & Clark County, and in Phase II of the Universal Access to Health Care Project, the Task Force will consider how funds might be reallocated to meet community health needs. In doing so, the Task Force will explore the specific suggestions made by community members and providers, review solutions implemented in other counties and states, and develop an action plan for the county to take steps toward universal access to care.